

FAMILY AND FINANCIAL THERAPY OF FLORIDA

4055 NW 43rd Avenue Suite 21
Gainesville, Florida 32606

Info@FamilyandFinancialTherapy.com
352-641-0239

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical treatment team members. I will seek authorization to discuss your case with anyone including your attorney, other family members and any professional to which I may refer you to. Please understand that if you are separated or divorced, the non-custodial parent may have specific rights to certain information.

For Health Care Operations: I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. PHI information may be used for appointment reminders and clinical follow-up contacts.

Required by Law: Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule and I must make PHI and client records available if I am investigated by the State of Florida regulatory licensing board that governs my license.

Without Authorization: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child and/or elder abuse or neglect or mandatory government agency audits or investigations (such as my licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- In cases of separation or divorce, parents with shared custody or the non-custodial parent, per terms of the separation or divorce decree, may have a right to a written report regarding their child's course of treatment without your authorization.

FAMILY AND FINANCIAL THERAPY OF FLORIDA

4055 NW 43rd Avenue Suite 21
Gainesville, Florida 32606

Info@FamilyandFinancialTherapy.com
352-641-0239

Verbal Permission: I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law *will be made only with your written authorization*. This authorization may be revoked. I request that you make that authorization in writing to me. Adult family members participating in family or couple's therapy must both give written authorization for any information to be disclosed.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You have the following rights regarding Personal Health Information I maintain about you. To exercise any of these rights, please submit your request in writing to me.

• **Right of Access to Inspect and Copy.** Under Federal HIPAA statutes you have the right to inspect and copy PHI that may be used to make decisions about your care. However, current Florida state law which is more stringent and currently takes precedence (Health/Human Services Section: 160.201, 160.202, 160.203, 160.204 Preemption of State Law and Florida Statute. 456.057 "Ownership and control of patient records report or copies of records to be furnished") maintains that the provider of services (Katie Fields) is the owner of the record, not the client, and has the option to write a narrative report regarding "examination and treatment in lieu of records." ***Therefore, it is my policy to not release your actual clinical record or Personal Health Information to anyone except the US Department of Human Services or my regulatory board under circumstances outlined in Required by Law, Without Authorization or a court order signed by a judge.***

However, upon your written request I will be happy to write a narrative report concerning your treatment, which will include PHI, your clinical information, to your attorney, other health providers, and/or other legal entities.

- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I'm not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that I may make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing directly to me or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. If you choose to lodge a complaint with this office or with the Secretary, you will not be disadvantaged by me in any manner.

**FAMILY AND FINANCIAL THERAPY
OF FLORIDA**

4055 NW 43rd Avenue Suite 21
Gainesville, Florida 32606

Info@FamilyandFinancialTherapy.com
352-641-0239

HIPAA- Notice of Privacy Practices- Receipt and Acknowledgement of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Family and Financial Therapy of Florida LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Family and Financial Therapy of Florida LLC for more information or clarification.

I consent to accept these policies as a condition of receiving mental health services.

Signature of Client

Date

Signature of Parent/Guardian or Personal Representative*

Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.) and provide appropriate documentation.